MEDI-CAL DISCLOSURE STATEMENT

FOR STATE USE ONLY

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: Department of Health Services
  Provider Master File Unit
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Legal name of applicant or provider name	Provider number

Type of entity: ❒ Sole Proprietor ❒ Partnership ❒ Corporation ❒ Limited liability corporation ❒ Other: ______________________________

Action requested (check one): ❒ New statement ❒ Change to previously submitted statement (provide new information only in the applicable sections)

1. List the requested information below for each person with an ownership or control interest in applicant or provider, all corporate officers and directors of corporations, and all partners in partnerships. If additional space is needed, please use copies of this page and attach to this form. **Each person listed below shall complete Attachment A.**

Full legal name (last) (first) (middle)

Title | Ownership or control interest percentage %

Is this person related to any other person with an ownership or control interest in applicant or provider? ❒ Yes ❒ No

If yes, please check the appropriate box and list who the person is related to:______________________

❒ Spouse ❒ Parent ❒ Child ❒ Sibling ❒ Other (explain):______________________

Full legal name (last) (first) (middle)

Title | Ownership or control interest percentage %

Is this person related to any other person with an ownership or control interest in applicant or provider? ❒ Yes ❒ No

If yes, please check the appropriate box and list who the person is related to:______________________

❒ Spouse ❒ Parent ❒ Child ❒ Sibling ❒ Other (explain):______________________

Full legal name (last) (first) (middle)

Title | Ownership or control interest percentage %

Is this person related to any other person with an ownership or control interest in applicant or provider? ❒ Yes ❒ No

If yes, please check the appropriate box and list who the person is related to:______________________

❒ Spouse ❒ Parent ❒ Child ❒ Sibling ❒ Other (explain):______________________

Full legal name (last) (first) (middle)

Title | Ownership or control interest percentage %

Is this person related to any other person with an ownership or control interest in applicant or provider? ❒ Yes ❒ No

If yes, please check the appropriate box and list who the person is related to:______________________

❒ Spouse ❒ Parent ❒ Child ❒ Sibling ❒ Other (explain):______________________

Full legal name (last) (first) (middle)

Title | Ownership or control interest percentage %

Is this person related to any other person with an ownership or control interest in applicant or provider? ❒ Yes ❒ No

If yes, please check the appropriate box and list who the person is related to:______________________

❒ Spouse ❒ Parent ❒ Child ❒ Sibling ❒ Other (explain):______________________

2. List the requested information for each person, including corporate officers and directors for corporations and all partners in partnerships, with an ownership or control interest in any subcontractor in which applicant or provider has a direct or indirect ownership interest of five percent or more. If additional space is needed, make copies of this page and attach to the application package.

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Full legal name (last) (first) (middle)

Residence address (number, street)

City | State | Nine-digit ZIP code

Subcontractor full name

Subcontractor address (number, street) | City | State | Nine-digit ZIP code

Is this person related to any other person with an ownership or control interest in applicant or provider listed in number 1? ❒ Yes ❒ No
If yes, please check the appropriate box: ❒ Spouse ❒ Parent ❒ Child ❒ Sibling ❒ Other (explain): _____

Full legal name (last) (first) (middle)

Residence address (number, street) | City | State | Nine-digit ZIP code

Subcontractor full name

Subcontractor address (number, street) | City | State | Nine-digit ZIP code

Is this person related to any other person with an ownership or control interest in applicant or provider listed in number 1? ❒ Yes ❒ No
If yes, please check the appropriate box: ❒ Spouse ❒ Parent ❒ Child ❒ Sibling ❒ Other (explain): _____

3. List the requested information for each person, including corporate officers and directors of corporations and all partners in partnerships, with an ownership or control interest in any subcontractor with whom the applicant or provider has had business transactions involving health care services, goods, supplies, and merchandise related to the provision of services to Medi-Cal beneficiaries totaling more than $25,000 during the 12-month period immediately preceding the date of the application, or immediately preceding the date of the Department of Health Services' request for such information. If additional space is needed, please use copies of this page and attach to the application package.

Full legal name (last) (first) (middle)

Residence address (number, street) | City | State | Nine-digit ZIP code

Full legal name (last) (first) (middle)

Residence address (number, street) | City | State | Nine-digit ZIP code

4. List any significant business transactions between the applicant or provider, including corporate officers and directors of corporations and all partners in partnerships, and any wholly-owned supplier, during the five-year period ending on the date of the application, or ending on the date of the written request by the Department of Health Services for such information. If additional space is needed, please use copies of this page and attach to the application package.

Name of supplier

Explain: _____

Name of supplier

Explain: _____

5. List any significant business transactions between the applicant or provider, including corporate officers and directors of corporations and all partners in partnerships, and any subcontractor, during the five-year period ending on the date of the application, or ending on the date of the written request by the Department of Health Services for such information. If additional space is needed, please use copies of this page and attach to the application package.

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Name of subcontractor

Explain:

Name of subcontractor

Explain:

6. a. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent, or managing employee been convicted of any felony or misdemeanor involving fraud or abuse in any government program within five years prior to the date of this statement? ❒ Yes ❒ No
If yes, please give the name, date of conviction, and explain:

b. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent, or managing employee been found liable for fraud or abuse involving a government program in any civil proceeding within five years prior to the date of this statement? ❒ Yes ❒ No
If yes, please give the name, date of final judgement, and explain:

c. Has applicant, provider, any person with an ownership or control interest in applicant or provider, agent, or managing employee entered into a settlement in lieu of conviction for fraud or abuse involving a government program within five years prior to the date of this statement? ❒ Yes ❒ No
If yes, please give the name, date of settlement, and explain:

7. Does the applicant or provider currently participate or has the applicant or provider ever participated as a provider in the Medi-Cal program? ❒ Yes ❒ No
If yes, please provide the following information:

Name(s)	Medi-Cal Provider Number(s)

8. Has applicant or provider ever participated as a provider in another state's Medicaid program? ❒ Yes ❒ No
If yes, please provide the following information:

State	Full Legal or Business Name	Medicaid Provider Number(s)

9. Has applicant or provider ever been suspended from a Medicare or Medicaid program? ❒ Yes ❒ No
If yes, please provide the following information:

Effective Date(s) of Suspension	Date(s) of Reinstatement, As Applicable	Medicare and/or Medicaid Provider Number(s)

10. Has the individual license, certificate, or other approval to provide health care, of the applicant or provider, ever been suspended or revoked? ❒ Yes ❒ No

If yes, please attach a copy of the written confirmation from the licensing authority that the professional privileges have been restored and provide the provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing Authority's Action

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11. Has applicant or provider otherwise lost or surrendered that license, certificate, or other approval while a disciplinary hearing was pending? ❒ Yes ❒ No

If yes, please attach a legible copy of the written confirmation from the licensing authority that the professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing

12. Has any licensing authority disciplined the license, certificate, or other approval to provide health care of the applicant or provider? ❒ Yes ❒ No

If yes, please provide the following information:

Action Taken	Where Action Was Taken	Effective Dates

FOR PHARMACY APPLICANTS OR PROVIDERS—ANSWER NUMBERS 13–15

13. Has the individual license, certificate, or other approval to provide health care, of the pharmacist-in-charge, ever been suspended or revoked? ❒ Yes ❒ No

If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing

14. Has the individual license, certificate, or other approval to provide health care, of the pharmacist-in-charge, ever been lost or surrendered? ❒ Yes ❒ No

If yes, please attach a copy of the written confirmation from the licensing authority that his/her professional privileges have been restored and provide the following information:

State(s) in Which Action Was Taken	Effective Date(s) of Licensing

15. Has any licensing authority ever disciplined the Board of Pharmacy License of the pharmacist-in-charge? ❒ Yes ❒ No

If yes, please provide the following information:

Action Taken	Where Action Was Taken	Effective Dates of Licensing Authority's Action

16. Does applicant or provider intend to sell or currently sell incontinence medical supplies? ❒ Yes ❒ No

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a. List the names and addresses for all current sources of capital:

Full name (last)	(first)	(middle)

Address (number, street)	City	State	Nine-digit ZIP code

b. List all manufacturers, suppliers, and other providers with whom the applicant or provider has any type of business relationship relative to the goods or services provided to Medi-Cal beneficiaries.

Business name	Business telephone number ( )

Address (number, street)	City	State	Nine-digit ZIP code

c. List all entities to which the applicant or provider has extended a line of credit of $5,000 or more.

Full name (last)	(first)	(middle)

Address (number, street)	City	State	Nine-digit ZIP code

I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document and the attachments is true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.

17. Printed name of applicant or provider	18. Signature

19. Executed at: _____, _____ on _____
(City) (State) (Date)

20. Notary Public—Please see number 20 in the instructions for who must notarize.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Health Care Financing Administration, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, Sacramento, CA, (916) 323-1945.

Applicant or provider legal name ***as shown on page 1***

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Medi-Cal provider number (not required of applicants new to the Medi-Cal program) | Date

A COPY OF THIS ATTACHMENT SHALL BE COMPLETED AND SUBMITTED TO THE APPLICANT OR PROVIDER BY EACH PERSON LISTED ON PAGE ONE OF THIS MEDI-CAL DISCLOSURE STATEMENT. APPLICANT OR PROVIDER SHALL SUBMIT ALL PAGES OF ATTACHMENT A WITH THE APPLICATION PACKAGE.

1. Full legal name (last) (first) (middle)

2. Residence address (number, street) | City | State | Nine-digit ZIP code

3. Social security number *(**Optional—**see Privacy Statement on page 5)* | 4. Date of birth | 5. Driver's license number or state-issued identification number (attach a legible copy)

6. List the name and address of any other health care provider in which you also have an ownership or control interest. If additional space is needed, please use copies of this page and attach to the application package.

Full name of health care provider (last) (first) (middle)

Address (number, street) | City | State | Nine-digit ZIP code

Full name of health care provider (last) (first) (middle)

Address (number, street) | City | State | Nine-digit ZIP code

7. a. Have you been convicted of any felony or misdemeanor involving fraud or abuse in any government program within five years from the date of this statement? ❒ Yes ❒ No
If yes, please explain:

b. Have you been found liable for fraud or abuse involving a government program in any civil proceeding within five years from the date of this statement? ❒ Yes ❒ No
If yes, please explain:

c. Have you entered into a settlement in lieu of conviction for fraud or abuse involving a government program within five years from the date of this statement? ❒ Yes ❒ No
If yes, please explain:

8. Do you currently participate or have you ever participated as a provider in the Medi-Cal program? ❒ Yes ❒ No
If yes, please provide the following information:

Name(s)	Medi-Cal Provider Number(s)

9. Have you ever participated as a provider in another state's Medicaid program? ❒ Yes ❒ No
If yes, please provide the following information:

State	Full Legal or Business Name	Medicaid Provider Number(s)

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10. Have you ever been suspended from a Medicare or Medicaid program? ❒ Yes ❒ No
If yes, please provide the following information:

Effective Date(s) of Suspension(s)	Date(s) of Reinstatement(s), As Applicable	Medicare and/or Medicaid Provider Number(s)

11. Has your individual license, certificate, or other approval to provide health care, ever been suspended or revoked? ❒ Yes ❒ No
If yes, please attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

Action Taken	Where Action was Taken	Effective Date(s) of Licensing Authority's Action

12. Have you otherwise lost or surrendered your license, certificate, or other approval to provide health care while a disciplinary hearing was pending? ❒ Yes ❒ No
If yes, please attach a copy of the written confirmation from the licensing authority that your professional privileges have been restored and provide the following information:

Action Taken	Where Action was Taken	Effective Date(s) of Licensing Authority's Action

13. Has your individual license, certificate, or other approval to provide health care ever been disciplined by any licensing authority? ❒ Yes ❒ No
If yes, provide the following information:

Action Taken	Where Action was Taken	Effective Date(s) of Licensing Authority's Action

INSTRUCTIONS FOR
THE MEDI-CAL DISCLOSURE STATEMENT

DO NOT USE correction tape, white out, etc., highlighter pen or ink of a similar type on this form.

Enter the legal name of the applicant or provider and the provider number, if applicable.

Check the type of entity of the applicant or provider.

Complete the Action Requested section by checking the appropriate box as to the submission of a new statement or changes to a previously submitted statement. Provide new information only in the applicable sections.

1. List full legal name, including last, first, and middle names, for each person or corporation with an ownership or control interest in applicant or provider (including officers and directors of an applicant or provider that is organized as a corporation and partners in an applicant or provider that is organized as a partnership) as listed with the Internal Revenue Service (IRS).
   - Person with an Ownership or Control Interest means a person or corporation that:
     - has an ownership interest of 5 percent or more in an applicant or provider;
     - has an indirect ownership interest equal to 5 percent or more in an applicant or provider;
     - has a combination of direct and indirect ownership interest equal to 5 percent or more in an applicant or provider;
     - owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or provider if that interest equals at least 5 percent of the value of the property or assets of the applicant or provider;
     - **is an officer or director of an applicant or provider that is organized as a corporation;**
     - **is a partner in an applicant or provider that is organized as a partnership.**
   - To determine percentage of ownership, mortgage, deed of trust, note or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation.
     - For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and shall be reported.
     - Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.
   - Indirect Ownership Interest means an ownership interest in any entity that has an ownership interest in the applicant or provider. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or provider. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity.
     - For example, if A owns 10 percent of the stock in a corporation which owns 80 percent indirect ownership interest in the applicant or provider and shall be reported.
     - Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the applicant or provider, B's interest equates to a 4 percent indirect ownership interest in the applicant or provider, B's interest equates to a 4 percent indirect ownership interest in the applicant or provider and need not be reported.
   - Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
   - Enter the title of the ownership interest.
   - Enter the percent of ownership the individual holds in the applicant or provider.
   - Check the box that defines the relationship between the person listed in number 1 and other ownership interests in the applicant or provider, if applicable.
2. List the requested information regarding anyone that has an ownership or control interest in a subcontractor that applicant or provider also has a direct or indirect ownership interest in.
   - Subcontractor means an individual, agency, or organization: (1) to which applicant or provider has contracted or delegated some of its management functions or responsibilities of providing medical care services, equipment, or supplies to its patients, and (2) with whom an applicant or provider has entered into a contract, agreement, purchase order, lease or leases for property, space, supplies, equipment, or services provided under the Medi-Cal agreement.
   - Ownership interest means the possession of equity in the capital, the stock, or the profits of the applicant or provider.

- Capital means the total of all money invested in, and property or services contributed to, an applicant's or provider's business enterprise for the purpose of starting, acquiring, equipping, and operating the applicant's or provider's business enterprise.
- Indirect ownership interest means an ownership interest in any entity that has an ownership interest in the applicant or provider, including an ownership interest in any entity that has an indirect ownership interest in the applicant or provider.

3. List the requested information for any person named in number 1 that has an ownership or control interest in any subcontractor with whom the applicant or provider has had business transactions that involve health care services, goods, supplies, and merchandise related to the provision of services to Medi-Cal beneficiaries and total more than $25,000 during the 12-month period immediately preceding the date of this application, or immediately preceding the date of the Department's request for such information.
4. List the requested information regarding significant business transactions between any wholly-owned supplier and applicant or provider during the five years prior to the date on the application or the period ending on the date of the Department's written request for such information.
   - Significant Business Transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of an applicant's or provider's total operating expenses.
   - Wholly-Owned Supplier means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.
5. List the requested information regarding significant business transactions between any subcontractor and applicant or provider during the five years prior to the date on the application or the period ending on the date of the Department's written request for such information. (See numbers 2 and 4 above.)
6. Check the appropriate boxes and explain any "Yes" answers.
7. Check the appropriate box and list all Medi-Cal provider numbers, if appropriate. If you cannot provide the numbers, please explain.
8. Check the appropriate box and list the state(s) and name(s) applicant or provider used when participating in another state Medicaid program, and all applicable provider numbers.
9. Check the appropriate box and, if applicable, provide the effective date(s) of suspension(s), date(s) of reinstatement and Medicare and/or Medicaid provider number.
10. Check the appropriate box and, if applicable, list the state(s) where applicant's or provider's license, certificate, or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
11. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
12. Check the appropriate box and, if appropriate, list the requested information.
13. Check the appropriate boxes and, if applicable, list the state(s) where the license, certificate, or other approval to provide health care of the pharmacist-in-charge was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
14. Check the appropriate boxes and, if applicable, list where the license, certificate, or other approval to provide health care of the pharmacist-in-charge was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
15. Check the appropriate boxes and, if appropriate, list the requested information.
16. a. If applicant or provider intends to sell or currently sells incontinence medical supplies, list the full legal name(s) and address(es) of all current sources of capital.
       - Capital means the total of all money invested in, and property or services contributed to, an applicant's or provider's business enterprise for the purpose of starting, acquiring, equipping, and operating the applicant's or provider's business enterprise.

    b. List all manufacturers, suppliers, and other providers with which the applicant or provider has any type of business relationship.
       - Supplier means any manufacturer, principal labeler, wholesaler, and any other primary supplier from which an applicant or provider purchases goods and services used in carrying out its responsibilities under Medi-Cal.

c. List all entities to which the applicant or provider has extended a line of credit of $5,000 or more.

- Line of Credit means a right granted by an applicant or provider to any other person or entity to defer payment to applicant or provider for the purchase of goods or services from applicant or provider up to a predetermined number of amount of goods or services or a predetermined amount of money.

17. Print the name of the individual signing the Medi-Cal Disclosure Statement. Enter the last, first, and middle name of an individual acting on behalf of and with authority to legally bind the applicant or provider as the sole proprietor, partner, corporate officer, or government official when applying to the Department of Health Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
18. An original signature of the individual listed in number 17 is required.
19. Include the city, state, and the date in the statement regarding where and when the application was signed.
20. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act DO NOT have to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

Attachment A Completion Instructions

1. List the name of the person listed in question 1 on the Disclosure Statement.
2. List the address where the named person lives.
3. Disclosure of the social security number is optional (See Privacy Statement on page 5.)
4. Enter the date of birth of the named person.
5. Driver's license number or state identification number means the driver's license or identification number issued by the state of residence. Attach a legible copy to the application.
6. Provide the name and address of all health care providers other than applicant or provider in which you also have an ownership or control interest. (See page 8, Instructions for the Medi-Cal Disclosure Statement, number 1, for definitions.)
7. Check the appropriate boxes and explain any "Yes" answers.
8. Check the appropriate box and list all Medi-Cal provider numbers, if appropriate. If you cannot provide the numbers, please explain.
9. Check the appropriate box and list the state(s) and name(s) applicant or provider used when participating in another state Medicaid program, and all applicable provider numbers.
10. Check the appropriate box and, if appropriate, list the requested information and attach a copy of the letter(s) of reinstatement.
11. Check the appropriate box and, if applicable, list the state(s) where the applicant or provider's license, certificate, or other approval to provide health care was suspended or revoked and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
12. Check the appropriate box and, if applicable, list the state(s) where the applicant's or provider's license, certificate, or other approval to provide health care was lost or surrendered while a disciplinary hearing was pending and the effective dates of those actions. Attach the written confirmation that professional privileges have been restored.
13. Check the appropriate box and, if applicable, indicate where the action was taken and the effective date of the action.